

# Medicaid Managed Care *Nursing Facilities - SB553 input:*

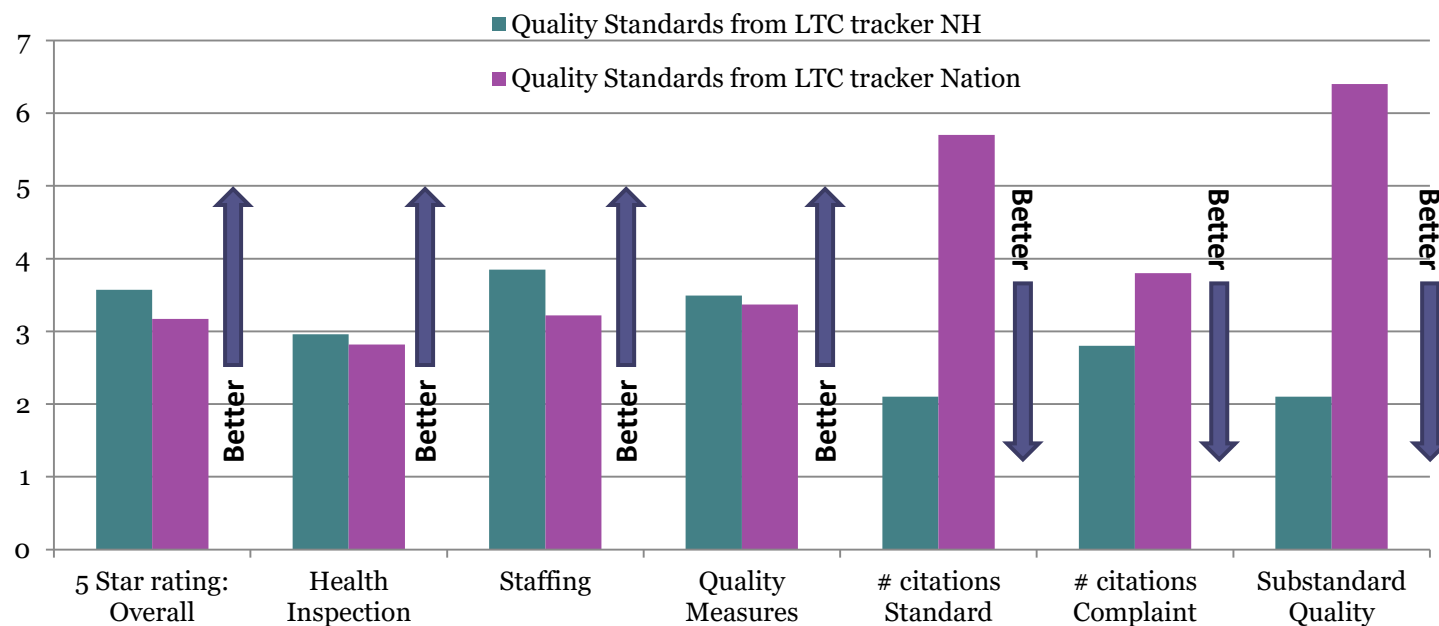
March 16, 2017

Presented by NH Health Care Association and NH Association of Counties  
and SB 553 work groups

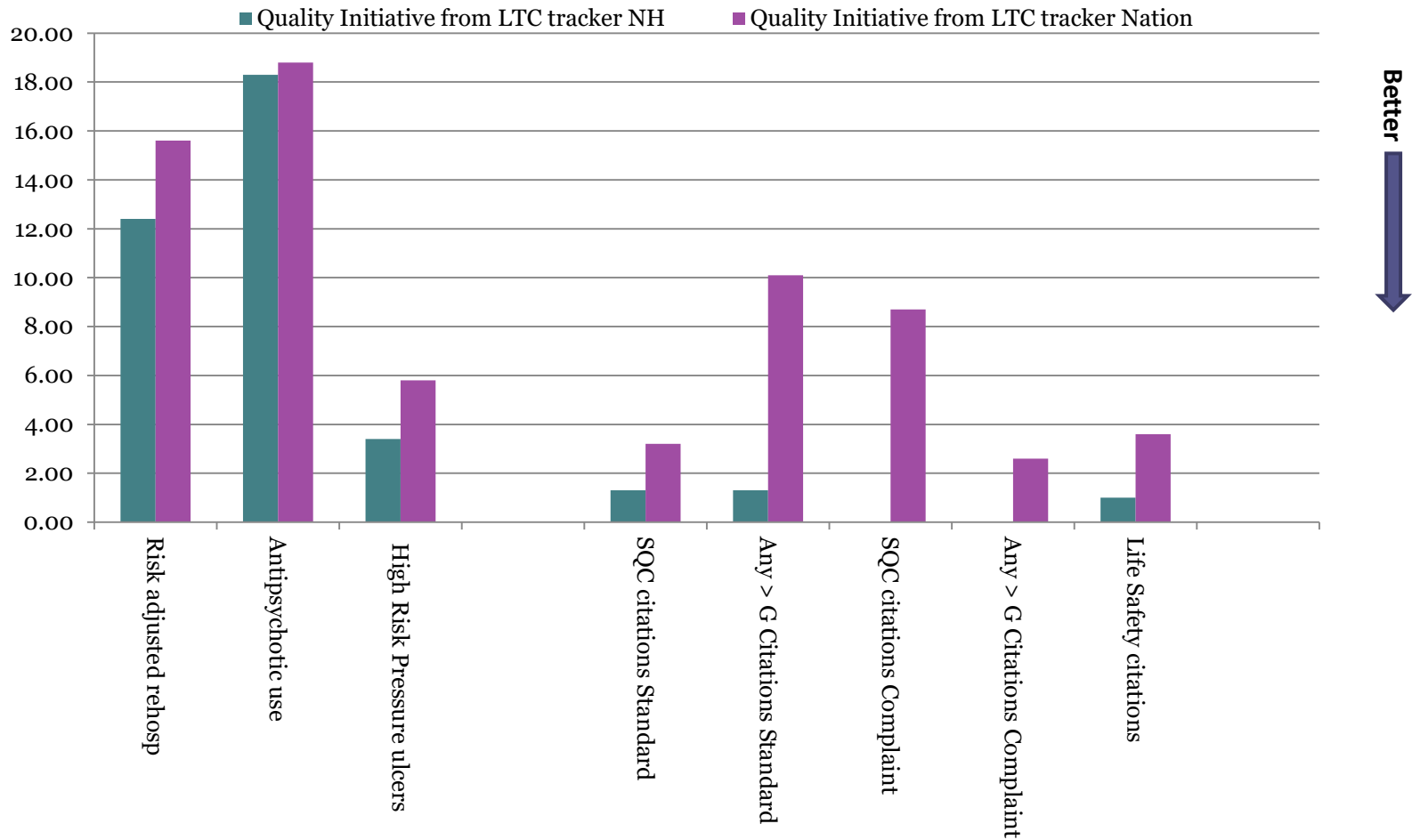
Value, Quality, Efficiency, Innovation and Savings  
*Nursing Facilities currently provide quality, value, efficiency,  
innovation and savings for NH*

- Quality of NH 's LTC services!
- Important principles for Nursing Facilities in MMC
  - Where is MMC taking us? Our questions

# Quality in LTC in NH - currently Accomplished thru Efficiency and Innovation

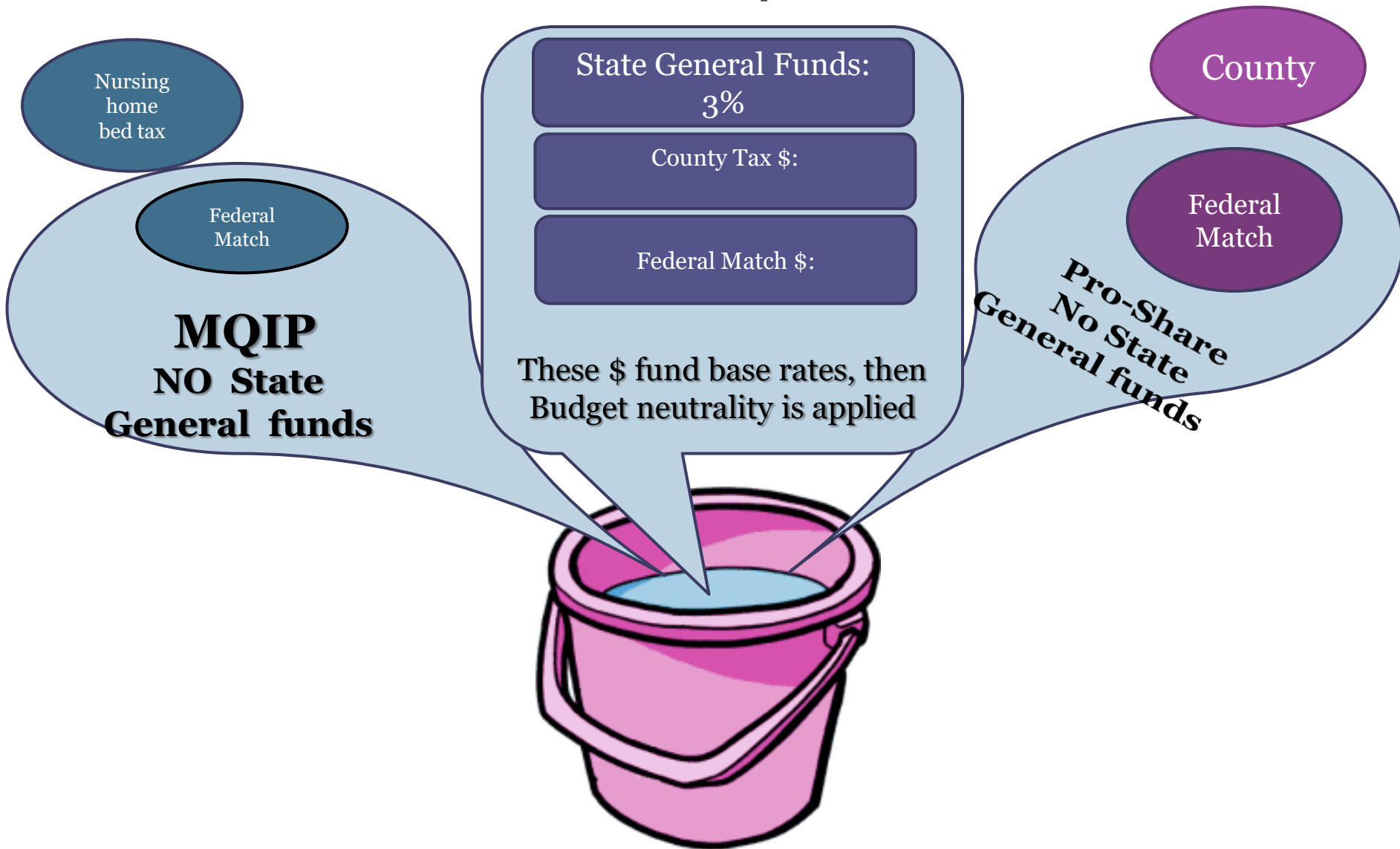


# Quality care in LTC in NH



# Where does our Medicaid funding come from?

## Who fills the \$ bucket?



# Current Rate “calculations” setting

- **Cost reports:** reduces costs to “allowable costs”
- **Caps applied:** “allowable costs” capped to median of base year collective costs
  - **Acuity** – 2x/ year & reweighted
- **Budget neutrality applied:** reduces calculated cost based payment rate to assure payments don’t exceed state budget.

Budget Neutrality Factor first appeared on rate sheets 10/2001 and was **2.75%**.  
2002 @ **5.96%**, 2/2003 @ **6.39%**, 8/2003 @ **14.69%** ..... 1/2014 **25.12%**  
January 1,2017 @**28.11%**

This funding challenges all providers to be efficient and innovative.

# Principles to Govern LTC Managed Care

## **Quality of care is paramount.**

The transition to MMC should not directly or inadvertently impair the quality of care or quality of life experienced by long term care recipients & nursing home residents.

- **Highly regulated Nursing Facilities must first comply with CMS Federal Guidelines:** Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. The requirements for participation were recently revised to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. The revisions were published in a final rule that became **effective on November 28, 2016**. Cost associated have not yet been realized by providers.
- [https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/som107ap_pp_guidelines_ltcf.pdf) - to download /
- <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

## Sustainable funding is critical to quality care and access.

- **NH DHHS should continue to be the rate setter for facility based care**, *but if it is to become a negotiated rate with the MCOs, then it needs **to transition over at least 4 years for stability of providers.** (precedent of Medicare changes and NH transition to acuity based Medicaid. )*
- Any “rebalancing” of the care delivery system, should not be funded at the further expense of nursing homes. **AND** other providers need to be funded to support quality care and choices, as well. (Assisted Living, Home Health, Home and Community Based Care.)
- Previously approved **capital cost** that have been **included in reimbursement rates** should continue to be recognized and compensated in any revised reimbursement formula, and the system should recognize the need for further capital improvement to aging facilities **and** continue to provide an **atypical rate for special populations**.
- The reimbursement formulas applied to any class of LTC services should be neutral to type or form of ownership. No form of ownership should be advantaged or disadvantaged by state policy. We understand that all payments need to be rolled into one rate under managed care. Pro-share and MQIP need to be included. . **Pro-Share and MQIP funding** are significant aspects of the reimbursement system and need to continue to flow to providers in an auditable / transparent methodology

# SB 553 Nursing Center Subgroup

Common threads found through out recommendations:

1. Providers must first operate under CMS rules
2. No Added administrative burden on providers: Consistent practice, policies and tools among MCOs
3. Rate Setting and eligibility should remain with DHHS

• Credentialing	• Eligibility and Enrollment
• Transitions	• Covered Services
• Pharmacy	• Transportation
• Prior Authorization	• Network Adequacy
• Quality Metrics & Outcome Measurement	• Patient Safety
• Grievances and Appeals	• Office of Ombudsman
• Rates and Payments	



**There should be no ADDED administrative burden on providers.**

### **Credentialing:**

- Any willing provider should be allowed to contract for MMC services - no added qualifications other than license, certification and demonstrated insurance coverage.
- The administrative processes of all MMC plans should be consistent for all major functions such as prior authorizations, claims processing and appeals for eligibility related matter.

### **Eligibility:**

- NH DHHS should continue to be responsible for determining clinical eligibility for nursing home care to assure uniform application of standards.
- Redetermination – 30 day grace period with notice to providers:
- Switches from MCO to MCO should term at the end of month and begin on First of the next month, like most insurance does.

## Transitions:

- All current Medicaid nursing home residents should be assured that they will not be discharged to another level of care unless they voluntarily, personally make such a request.
- Presume clinical eligibility from hospitals.
- Can DHHS request PASRR waiver? – often delays timely transitions to NF with no benefit to patient or provider.
- Assure Smooth transition of Medications, O2, equipment and services through level of care changes..
- Support home visits to include assessment of equipment needs, training needs and home supports, Avoiding acute readmits or ED visits.
- Case management support to begin 30 days pre-transition to community case management
- 90 day care plan preservation during any transition.

## **Utilization Management:**

- Standard Continued stay criteria among MCOs.
- Billing codes, Forms and procedures standardized. Billing documents standardized like Medicare's UBs.
- MCO changes in Administrative Rules give 30 day advance notice, in writing, to providers. DHHS provide review / appeal process for providers
- MCO billing systems should be tested / run in parallel before a final transition is made. Provide alternate billing portals / systems for providers.
- Notification and appeal process prior to recoupment or take back. Allow appeal within 30 days of notice. UM hearing committee by approval of MCO and provider. Arbitration option if either party requests.
- Agreed participation in UM/QA programs of MCOs, subject to provider's right to appeal any adverse decisions .

## Covered Services:

- Covered services mean those healthcare services, equipment and supplies that are required by federal and state laws to be covered under a Member's Benefit Program.
- The provider shall be entitled and compensated to provide all Covered Services for which it is licensed and required to provide under applicable laws and CMS regulations.
- Consistent application of Covered services MCO / MCO and Providers
- **DHHS list of Covered Services included in NF per diem must be reviewed and agreed upon. Example: Laboratory, Radiology and Inhalation Therapy are billed directly to Medicaid by outside providers.** Confusion in the labeling. Not consistent practice now.
- A-typical covered services need to listed separately and not delineated in comment area; such as vents. A partially revised list is provided, but more discussion with DHHS and providers needs to occur.

## **Covered services continued:**

- Dental care services are found not to address the preventive care and post extraction care needed for good, cost efficient healthcare.
- Respite benefit up to 35 days / year proposed;
- Prior Auth or supplemental payment request system for providers to justify one time events or short term, episodic funding.
- A- typical rate structure / covered services for patients / units for those with significant behavioral health needs. Current CMI valuing system is punitive to providers who care for those with these challenges.
- IF/ IID: Facility licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities serving the under 21 year old population have additional covered services.

## **Pharmacy: Is Not a covered service in per diem rate**

- Keep pharmacy as is: Any physician–ordered medications: FDA approved Legend and Non-legend drugs should be approved and covered without Prior Authorization
- Any Prior Authorization process for pharmacy can not cause a delay in getting medication to residents. 42 CFR 483.60 (F425) requires that the facility provide or obtain routine and emergency medication and biologicals in order to meet the needs of each resident. Surveyors allow 24 hrs. to comply.
- Assure smooth transitions of medication between MCO transitions, services level transitions, etc.
- Consistent pharmacy formulary among MCOs. Differences would create inefficiencies. Prior Auths only for off Formulary and applies to MEDICAID only residents, Not dual eligibles.
- Assure continuity of care with a 15 day medication supply for gaps/ lapse in coverage

## **Transportation:**

- Keep system, as revised in late 2015, recognizing that providers request transportation when medically necessary only. Eliminated delays & inefficiency.
- Providers who provide transportation, through CTS, request to remove burdensome and costly administrative requirements. Could there be a NF provider exemption?
- All MCOs, current or new, work with CTS, consistent practice.
- In areas where an approved provider is not available in the member area, MCO's cover the services of alternate provider.

## **Prior Authorization:**

- **Definition:** Pre- Authorization is a decision by a health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
- Providers must first operate under CMS Federal guidelines: 42 CFR – Part 483: Requirements for participation. Providers are required to follow best practice and document reasoning behind practice. Providers are required by these rules to manage and coordinate the care to allow the highest practicable level of function.
- Applies to Medicaid only. Not for Medicare or other primary insurance.
- No PA requirement for CMS required tasks, including certifications, recertification physician visits.



## **Prior Authorizations continued:**

- PA process can not slow down or interfere with prompt implementation as required by CMS – be cognizant of all current guidelines in place.
- MCOs must follow the same best practice guidelines as CMS requires.
- NF providers held harmless if another provider does not get appropriate auth.
- For continuity & efficiency, any PA in place must carry over to NEW MCO for a 6 month period, post enrollment.
- MCO agrees not to terminate such PAs without advance notice and opportunity for appeal of substantial reductions in services.

## **Network adequacy:**

- Reimbursement often drives provider participation.
- Include any willing provider.
- Choice should include private, county and private not for profit providers
- Cover all Regional areas
- Sufficient access to beds and services to meet need must be demonstrated.
- MCOs must demonstrate an adequate network of providers specializing in care needs of the populations residing in nursing homes. ie.: Dentist, mental health, behavioral health, podiatrist, etc. in their network
- Determination of current unmet need is require in order to assess network needs.

## **Network adequacy continued:**

- CMS and State must ensure beneficiary access to providers does not decrease.
- State and MCOs must be required to establish processes to encourage provider enrollment in MCO networks.
- MCOs must support community based transition programs to help enrollees, when appropriate, to community –based setting from NF and develop such programs where they do not exist or are minimal at best.
- Because enrollment in an MCO should never require a person to move from their home, an MCO must be required to make payment available to any licensed, certified NF in which an enrollee is living at the time of enrollment for services provided to that enrollee. That payment must reflect the network rate if that rate is higher than the fee for service rate.

## **Quality metrics and outcome measurements:**

- NF providers use existing publically reported CMS quality measures.
- MCOs utilize the most current metrics and measurements as set forth under CMS's Nursing Home Quality Initiative.
- MCOs must report / track any service lags related to a Prior Auth. processes.
- MCOs must report / track any consumer / provider complaints.
- MCO must report payment timeliness.
- MCO must report / track billing issues and resolutions.

## **Patient Safety:**

- NF provider agree, to best of its knowledge and ability, covered services shall be provided in accordance with all applicable federal and state laws.
- MCO acknowledges that State and Federal regulations require reporting of internal investigation within a facility . Such investigations and reporting of these incidents are NOT subject to reporting requirements of the MCO.
- MCO agrees that onsite inspections and investigations into members care are regulated by state and federal authorities. MCO agrees to accept information, investigation and outcome of internal investigatory process or that of regulatory authority in lieu of MCO conducting separate / own.
- State must have an oversight and monitoring plan that clarifies what role each of the relevant agencies will play. A clear lead agency, ultimately responsible for the program should be identified

## **Patient Safety continued:**

- State must restructure and rehire as necessary to ensure that staff have expertise in overseeing, monitoring, and contracting with MCOs.
- The state's oversight and monitoring plan must include activities to monitor MCO performance over time as well as activities that can quickly identify and resolve problems.
- State must utilize stakeholder groups and independent ombudsman in its monitoring and oversight plan

## **Grievance and Appeals:**

- In situations where disagreement arises over treatment decisions, The MCO's and Provider's Medical directors will discuss the case to determine a mutually agreeable solution.
- Resolution must be timely to not interrupt / delay care to beneficiary. And meet CMS guidelines. If MCO delays, provider will provide care and be reimbursed by MCO.
- Beneficiaries must maintain their existing Medicaid due process rights: including the right to notice and appeal of a MCO decision, including any decision to deny, reduce or terminate benefits.
- Decision- makers in the appeal process must be trained to evaluate the necessity of nursing home care
- MCO beneficiaries must have the right to file grievances about the services and treatment provided by the MCO, its contractors and providers.

## **Grievances and Appeals continued:**

- The state must collect, share publically, data on the rate of denials, including partial denials of requested services, the number of appeals and grievances filed and the number of appeals that result in the reversal of a MCO decision.
- Grievance and appeals process for both individual long term care recipients and long term care providers should be established that include accessible, knowledgeable, high level INDEPENDENT liaisons. In the case of recipients / beneficiaries, the liaison should function as a “managed care ombudsman” to assist through appeals and grievance process.



## **Office of Ombudsman:**

- The Managed Care Ombudsman is INDEPENDENT from Managed Care Plans
- Assists members in obtaining medically necessary covered services for which the managed care plan is contractually responsible.
- Provides plan member education on: managed care; member rights under managed care; grievance and appeals procedures.
- Assists in making referral to other advocacy agencies when appropriate.
- Assists individuals with navigating the managed care program, including: Understanding benefits, coverage or access rules and procedures, and participant right and responsibilities; Making enrollment decisions; Exercising right and responsibilities, including OLMSTEAD rights around community integration; Accessing benefits; resolving billing problems; appealing MCO denial, reduction or termination of services; raising and resolving quality of life issues; ensuring the right of privacy, consumer direction and decision-making; and understanding and enforcing civil rights.

## Office of the Ombudsman continued:

- MC Ombudsman should be accessible through telephonic helplines, and where appropriate, in-person appointment.
- MCOs must notify beneficiaries of availability of the MC ombudsman; in enrollment and other marketing materials, including annual notices summarizing grievances and appeal procedures; AND in all notices of denial, reduction or termination of a service – in writing or alternate method with adequate notice.
- The MC ombudsman must participate in participant advisory committee meetings with MCOs and State.
- Should prepare **public** reports to the state, at least annually
- Ombudsman must have channels of access to senior officials at the MCO and State. Meetings should occur regularly with MCOs and State to discuss patterns and systemic issues.
- The MC ombudsman must have the expertise / experience in the delivery of long-term care supports and services.

## **Rates and Payments:**

- Fair and Adequate rates facilitate access; any historical rate history does NOT reflect future needs related to staffing needs and changes in regulation impacting costs.
- Any MC overhead cost % must not be taken from rates.
- Rate setting should remain with DHHS, allowing for recognized costs as validated by Medicaid Cost reports and provide consideration for resident acuity and capital costs.
- Rates should be at least equal to the combined Medicaid payment rate plus MQIP. ProShare must be added to County nursing facilities.
- Atypical rates should be developed for specialized units / facilities (including Cedar Crest and Crotched Mountain). Atypical rates need to be developed for behavioral patients / units to support access and service.
- Under 21 services at Cedarcrest and Crotched Mountain services are specific and differ from other LTC inpatient services and have different rate need.

## **Rates and Payments continued:**

- Clean bills paid with 15 days.
- NFs should bill within 90 days of service, except for delays in eligibility.
- For purposes of a MMC agreement, a Clean Claim mean a claim which contains all of the (UB- 92 or HCFA 1500 or successor standard) data elements and is submitted within the time frames set forth.
- Changes in billing format require training for providers and notice.
- Billing data fields should be consistent across MCOs so facilitate efficiency and reduce errors.
- The MCO will pay interest at the rate of 15% per annum on clean claims paid after 45 of receipt.
- Prior to any NF / ALF recoupment, detailed notice in writing - describing basis, the process to recoup, the total recoupment, # of claims, dates, and appeal rights. Provider should receive an electronic file with Patient ID, dates of service, claim numbers, dates of payment, amounts paid and amounts to be recouped from MCO.
- Recoupment will occur within one year after the claim has been adjudicated.
- **NO rate decrease to providers - already highly at risk!**

# Suggested Timeframe to successfully implement Step 2

• Develop concurrence among DHHS, MCOs and provider community of principles, including payment system, that will guide contract framework between DHHS and MCOs and between MCOs and providers.	<b>6 months</b>
• Negotiate & Develop State to MCO contract terms Re LTCSS	<b>3 months</b>
• File CMS 1115 waiver (based on outcome of contracts) ???	<b>1 month</b>
• Negotiate & Develop MCO to LTC provider contract terms, reimbursement system, quality measures, payment methodology,	<b>5 months</b>
• Educate providers, recipients and families on managed care contracts	<b>2 months</b>
• Initiate and conduct mandatory enrollment of LTC recipients (after contract terms are completed and explained)	<b>2 months</b>
• Initiate managed care contracts in alignment with state budget cycle	<b>July 2019?</b>

# Moving forward.....

- LTC provider community, private and county, is willing to partner with DHHS and MCOs to successfully implement Step 2, upon understanding the benefits to be derived from this transition. We need to understand the goals.
- We want to do it RIGHT!
  - Assure we can continue to improve the services those in our care receive;
  - Assure proper funding to support our services and our caregivers.

# Global questions:

1. What are the goals and objectives of implementing managed care for the nursing home and mid-level residential populations? In particular:
  - a. What, if any, specific quantifiable financial savings opportunities, identified by NH DHHS, are expected to be achieved by implementing managed care for nursing home residents?
  - b. What specific or quantifiable quality improvement or care coordination opportunities, identified by NH DHHS, are expected to be achieved by implementing managed care for nursing home residents?
  - c. In light of the very low Medicaid reimbursement rates for Residential Care services and the resulting very low acceptance of Residential Care residents by the provider community, does NH DHHS see an opportunity to adjust mid-level care rates so that additional facilities will accept Medicaid recipients and provide a viable placement option for lower acuity individuals who need 24 hr. access to supportive care?
  - d. What specific quantifiable financial savings or improvements in quality of care coordination are expected to be achieved by implementing managed care for Mid-level “Residential Care or Supported Residential Care” residents?

## *Global questions continued:*

2. What systems will be put in place to monitor the care received by residents of nursing homes, given this population's limited ability to self-report disruptions in service that may be triggered by systematic changes? What if any consideration has been given to the totality of this population's dependence on the care provided by nursing homes and affiliated ancillary service providers?
  - a. What are the potential care coordination and care delivery problems that DHHS has identified as being the most likely to arise as a result of any anticipated changes resulting from implementation of managed care, and what potential way of monitoring these problems have been identified?



## *Global questions continued:*

3. What, if any, changes might be made to the scope of covered or “routine” services to be included in a per diem rate?
4. Will either “financial” or “clinical” eligibility criteria for LTC Medicaid change in any way?
5. **New CMS Rules** – How will the new Proposed CMS Medicaid Managed Care Rules impact this process? How will “actuarially sound” rate setting impact budgets?



**Thank you for this opportunity,  
your time, and attention!**

***We are available to answer questions***